KINSALE®
EXPLORE THE POTENTIAL

AMBULATORY SURGERY CENTER RENEWAL APPLICATION

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the expiring effective date of coverage.
- If a question is not applicable, then state "N/A".

GENERAL INFORMATION

1. Full name of Applicant (Including DBA's) ____________________

2. Indicate change(s) in general information below.
   Check here if **NO** change(s) in general information from last year: ☐

3. Mailing / Location Address(es):

   (1) ____________________
   STREET CITY COUNTY STATE ZIP

   (2) ____________________
   STREET CITY COUNTY STATE ZIP

   Attach Additional Pages as Needed

4. Provide any other general information change(s) below:
   ____
   ____

5. Inspection/Risk Management Contact Name: ____________________

6. Inspection/Risk Management Contact E-mail: ____________________

APPLICANT'S PRACTICE

7. Is the applicant accredited by or a member of any professional organization or association? Yes ☐ No ☐
   If yes, please name: ____________________

8. Estimated annual gross revenues in the next 12 months? $__________

   Annual gross revenues in the past 12 months? $__________

9. Does applicant maintain beds for overnight occupancy? Yes ☐ No ☐
   If yes, how many? ______ Also attach a copy of license and an explanation including protocols for onsite 24 hour staffing.

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10. Please provide number of procedures / services for the following:

TYPE OF PROCEDURE	NUMBER PAST 12 MONTHS	ESTIMATED NUMBER NEXT 12 MONTHS
Abortions		
Bariatric Surgery - *List Procedures Below*		
Cosmetic Surgery		
Dental/ Oral Surgery		
Endoscopy/ Colonoscopy		
General Surgery		
Gynecological Surgery		
Manipulation under Anesthesia		
Obstetric		
Ophthalmology - Cataract		
Ophthalmology – Lasik / Refractive		
Orthopedic Surgery		
Orthopedic Surgery – Including Spine		
Otorhinolaryngology with Plastic		
Otorhinolaryngology no Plastic		
Pain Management – *List Procedures Below*		
Plastic/ Reconstructive Surgery		
Podiatry		
Radiological/ Nuclear/ Chemotherapy		
Other: (describe)		
Other: (describe)		
Other: (describe)		

11. **IF BARIATRIC SURGERY OR PAIN MANAGEMENT** is indicated please complete the following
    a. Please list ALL bariatric or pain management procedures and **attach** protocols for selecting and monitoring patients.

    ____
    ____
    ____
    ____

    b. Is Bariatric surgery **only** performed by American Board Certified General Surgeons? If no, on a separate page please describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform this procedure Yes☐ No ☐ N/A ☐
    c. Is this center a Bariatric Surgery Center of Excellence? Yes☐ No ☐ N/A ☐

STAFF / CREDENTIALED PROVIDERS

12. Please complete the staff / credentialed provider table below **AND** provide a staff listing by name for all credentialed physicians.

	Number Employed?		**Number Privileged**		Insured Elsewhere?	Coverage Desired?
	Full Time	Part Time	Full Time	Part Time		
Physicians: no surgery other than incision of boils and superficial abscesses; suturing of skin or superficial fascia					☐ YES ☐ NO	☐ YES ☐ NO
Anesthesiologists; Pain Management Specialists					☐ YES ☐ NO	☐ YES ☐ NO
Dermatologist; Cardiologists; Gastroenterologist; Proctologists; Ophthalmologists; Urologists, Internists;					☐ YES ☐ NO	☐ YES ☐ NO
General Surgeons; Cardiac Surgeons;					☐ YES ☐ NO	☐ YES ☐ NO
Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery					☐ YES ☐ NO	☐ YES ☐ NO
Thoracic Surgeons; Vascular Surgeons; Neurosurgeons; and Orthopedic Surgeons					☐ YES ☐ NO	☐ YES ☐ NO
Bariatric Surgeons					☐ YES ☐ NO	☐ YES ☐ NO
Podiatrists					☐ YES ☐ NO	☐ YES ☐ NO
Dentists; Oral Surgeons					☐ YES ☐ NO	☐ YES ☐ NO
Nurse Anesthetists					☐ YES ☐ NO	☐ YES ☐ NO
Physicians' and Surgeons' Assistants; Nurse Practitioners					☐ YES ☐ NO	☐ YES ☐ NO
Perfusionists					☐ YES ☐ NO	☐ YES ☐ NO
Pharmacists					☐ YES ☐ NO	☐ YES ☐ NO
Chiropractors					☐ YES ☐ NO	☐ YES ☐ NO
RNs, LPNs					☐ YES ☐ NO	☐ YES ☐ NO
X-Ray Technician; Lab Technician					☐ YES ☐ NO	☐ YES ☐ NO
Other (specify):						

CLAIMS AND HISTORY – Please explain or complete a supplemental claim for form for all "Yes" answers

13. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? If Yes, complete a supplemental claims form for each. ☐ YES ☐ NO

14. Has the applicant or any of its employees ever had any professional license or license to prescribe and or dispense narcotics ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **Explain below or attach additional pages as needed** ☐ YES ☐ NO

15. Has the applicant or any of its employees ever been charged with, or convicted of a crime **other** than minor traffic violations? **Explain below or attach additional pages as needed** ☐ YES ☐ NO

16. Has the applicant or any of its employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? **Explain below or attach additional pages as needed** ☐ YES ☐ NO

17. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? **If yes, please explain in detail, completing a supplemental claim form for each.** ☐ YES ☐ NO

SUPPLEMENTAL INFORMATION (reference question number if applicable)

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FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.
The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion. Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: ______________________________ Title: ______________________________

FEIN #: ______________________________

Applicants Signature: ______________________________ Date: ______________________________

Agent/Broker Name: ______________________________

SUPPLEMENTAL CLAIM / INCIDENT INFORMATION

If reporting more than one claim or incident, please photocopy and complete a separate form for each. <u>Attach additional sheets if necessary for adequate explanation.</u> All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient: ______________________________ Age: ________ Sex: _________

Incident ☐ Claim ☐

Date reported to insurance company: ______________________________

Name of insurance company: ______________________________

Date of incident and your treatment: ______________________________

Allegations / Circumstances:

____

____

____

Additional Defendants: ______________________________

What is the present condition of the patient?

____

____

<u>STATUS OF CLAIM</u>

☐ Suit threatened, no action taken

☐ Suit filed but dropped by claimant

☐ Summary judgment in your favor

Court outcome in YOUR favor:

☐ Jury verdict

☐ Directed verdict

Unresolved/Open

☐ Awaiting mediation

☐ Awaiting court action

Reserve amount:

$_________________

☐ Suit settled out of court

a. Date claim paid: _____________

b. Amount paid: $_____________

Did you want to settle? ☐ Yes ☐ No

Court outcome in favor of plaintiff:

☐ Jury verdict

☐ Directed verdict

Amount of loss payment: $_____________________

Name and address of the attorney assigned to your case: ______________________________

____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

Yes: ☐ No: ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

____

____

____

Signature: ______________________________ Date: ______________________________

Printed Name: ______________________________